

“DRG daily rate,” means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the DRG average length of stay.

“DRG rate” means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse hospitals for routine and ancillary costs of providing care for an inpatient stay.

“Free-standing” hospital does not mean a wing or specialized unit within a general acute care hospital.

“Hospital Market Basket Index” or “Market Basket Index” or “Index” means the DRI-Type Hospital Market Basket Index, published quarterly by DRI/McGraw Hill in “Health Care Costs”.

Inpatient” means a Medicaid patient who was admitted to a medical facility on the recommendation of a physician and who received room, board and professional service in the facility.

“Inpatient hospital facility” means a general acute care hospital, a mental health institution, a state mental health institution or a rehabilitation inpatient facility properly licensed as a hospital in accordance with appropriate Indiana Code.

“Intestinal transplant” means the grafting of either the small or large intestines from a donor into a recipient.

“Less than one-day stay” means a medical stay of less than twenty-four (24) hours that is paid according to a DRG rate.

“Level-of-care case” means medical stay that includes psychiatric cases, rehabilitation cases, certain burn cases and long term care hospital admissions.

“Level-of-care rate” means a per diem rate that is paid for treatment of a diagnosis or performing a procedure.

“Long term care hospital” means a free-standing general acute care hospital licensed under IC 16-21 that:

- (1) is designated by the Medicare program as a “long term hospital”, or
- (2) has an average inpatient length of stay greater than twenty-five (25) days, as determined using the same criteria used by the Medicare program to determine whether a hospital’s average length of stay is greater than twenty-five (25) days.

“Medicaid day” means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day.

“Medicaid stay” means an episode of care provided in an inpatient setting that includes at least on (1) night in the hospital and is covered by the Indiana Medicaid program.

“Medicaid education costs” means the costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.

**“Multivisceral transplant” means the grafting of either the small or large intestines and one or more of the following organs from a donor into a recipient: liver, pancreas or stomach.**

“Office” means the Office Medicaid Policy and Planning of the Indiana Family and Social Services Administration.

“Outlier payment amount” means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

“Per diem” means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

“Principal diagnosis” means the diagnosis, as described by ICD-9-CM code, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

“Readmission” means that a patient is admitted into the hospital within fifteen (15) days following a previous hospital admission and discharge for a related condition as defined by the office.

“Rebasing” means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

“Relative weight” means a numeric value that reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

Routine and ancillary costs” means costs that are incurred in the providing services exclusive of medical education and capital costs.

“Transfer” means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

“Transferee hospital” means the hospital that accepts a transfer from another hospital.

“Transferring hospital” means the hospital that initially admits then discharges the patient to another hospital.

## **PROSPECTIVE REIMBURSEMENT METHODOLOGY**

The purpose of the section is to establish a prospective reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective

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system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology **or, in the case of intestinal or multivisceral transplants, ninety percent (90%) of reasonable costs.** Prospective payment shall constitute full reimbursement. There shall be no year-end cost settlement payments.

Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all-patient DRG grouper. The DRG rate is equal to the relative weight multiplied by the base amount.

Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate, the medical education rate if applicable, and, the outlier payment amount, if applicable.

Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate if applicable, and the outlier payment amount, if applicable.

Relative weights will be reviewed annually by the office and adjusted not more often than every second year using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. After January 1 2002, relative weights will be reviewed by the office and adjusted annually using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandate affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine whether an adjustment to the relative weights will be made. DRG average length of stay values will be revised when relative weights are adjusted.

A base amount is the rate per Medicaid stay. DRG base amounts will be reviewed annually by the office and adjusted not more often than every second year using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, the base amounts will be inflated using the most recently available DRI/McGraw Hill Hospital Market Basket Index. Rebasing of the base amount will apply information from the most recent available cost report that has been filed and audited by the office or its contractor.

The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjusted cost per discharge greater than one standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred and twenty percent (120%) of the statewide base amount for DRG services.

**The reimbursement methodology for all covered intestinal and multivisceral transplants shall be ninety percent (90%) of reasonable cost, until such time an appropriate DRG as determined by the office can be assigned.**

Level-of-care rates per diem rates. Level-of-care rates will be reviewed annually by the office and adjusted no more often than every second year by using the most reliable claims data.

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